

		FOR OHF USE					

LL 1

**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0031468</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>MONTEBELLO HEALTHCARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>16TH & Keokuk</u> <u>Hamilton</u> <u>62341</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>HANCOCK</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(217) 847-3931</u> Fax # <u>(217) 847-2049</u>		(Type or Print Name) <u>LINDA HOLTZSCHEITER</u>	
IDPA ID Number: <u>752080781001</u>		(Title) <u>REIMBURSEMENT MANAGER</u>	
Date of Initial License for Current Owners: <u>08/01/86</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>Cathy Simeoni</u> <u>Manager - Healthcare Consulting</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Kellogg & Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(714) 596-7713</u> Fax # <u>(714) 596-7721</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Cathy Simeoni</u> Telephone Number: <u>(714) 596-7713, Ext 12</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER# 0031468 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>139</u>	TOTALS	<u>139</u>	<u>50,735</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>4,020</u>	<u>4,020</u>	8
9	SNF/PED					9
10	ICF	<u>21,787</u>	<u>7,502</u>	<u>59</u>	<u>29,348</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,787</u>	<u>7,502</u>	<u>4,079</u>	<u>33,368</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 65.77%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 139 and days of care provided 3,976Medicare Intermediary AdminaStar, Illinois

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **MONTEBELLO HEALTHCARE CENTER** # **0031468** Report Period Beginning: **1/1/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	122,651	12,689	12,150	147,490		147,490		147,490			1
2	Food Purchase		135,603		135,603		135,603		135,603			2
3	Housekeeping	78,929	12,675	193	91,797		91,797		91,797			3
4	Laundry	34,826	14,746		49,572		49,572		49,572			4
5	Heat and Other Utilities			82,774	82,774		82,774	343	83,117			5
6	Maintenance	26,947	22,577	15,571	65,095		65,095	161	65,256			6
7	Other (specify):*											7
8	TOTAL General Services	263,353	198,290	110,688	572,331		572,331	504	572,835			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	942,413	63,615	33,471	1,039,499		1,039,499	10,339	1,049,838			10
10a	Therapy	105,620	2,635	9,415	117,670		117,670		117,670			10a
11	Activities	44,266	5,744	1,840	51,850		51,850		51,850			11
12	Social Services	46,347		2,205	48,552		48,552		48,552			12
13	Nurse Aide Training											13
14	Program Transportation	10,850		45	10,895		10,895		10,895			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,149,496	71,994	53,576	1,275,066		1,275,066	10,339	1,285,405			16
	C. General Administration											
17	Administrative	64,486			64,486		64,486		64,486			17
18	Directors Fees											18
19	Professional Services			1,404	1,404		1,404	3,393	4,797			19
20	Dues, Fees, Subscriptions & Promotions			3,540	3,540		3,540	106	3,646			20
21	Clerical & General Office Expenses	76,128	9,200	88,623	173,951		173,951	51,405	225,356			21
22	Employee Benefits & Payroll Taxes			283,592	283,592		283,592		283,592			22
23	Inservice Training & Education			2,689	2,689		2,689		2,689			23
24	Travel and Seminar			10,600	10,600		10,600	10,559	21,159			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,444	96,444		96,444	(46,143)	50,301			26
27	Other (specify):*											27
28	TOTAL General Administration	140,614	9,200	486,892	636,706		636,706	19,320	656,026			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,553,463	279,484	651,156	2,484,103		2,484,103	30,163	2,514,266			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **MONTEBELLO HEALTHCARE CENTER** #0031468 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			128,834	128,834		128,834	31,213	160,047			30
31	Amortization of Pre-Op. & Org.			111,145	111,145		111,145		111,145			31
32	Interest											32
33	Real Estate Taxes			53,897	53,897		53,897		53,897			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,770	12,770		12,770		12,770			35
36	Other (specify):*							17,382	17,382			36
37	TOTAL Ownership			306,646	306,646		306,646	48,595	355,241			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,470	12,257	56,727		56,727		56,727			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*			4,946	4,946		4,946		4,946			43
44	TOTAL Special Cost Centers		44,470	93,306	137,776		137,776		137,776			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,553,463	323,954	1,051,108	2,928,525		2,928,525	78,758	3,007,283			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER

0031468

Report Period Beginning:

1/1/01

Ending:

12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,378)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,109)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	21		28
29	Other-Attach Schedule	(21,542)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (61,484)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	139,787		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 139,787		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 78,303		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
MONTEBELLO HEALTHCARE CENTER

Page 5A

ID# 0031468
 Report Period Beginning: 1/1/01
 Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Tax	\$ (1,897)	21	1
2				2
3	Open House Expense	(21)	21	3
4	FAS 121*	35,105	30	4
5	Vending Receipts	(1,195)	21	5
6	Professional Liability Insurance	(44,005)	26	6
7	Depreciation Reconciliation	(3,892)	30	7
8	Marketing Wages	(5,182)	21	8
9				9
10				10
11	**The facility re-valued their assets in 1999. We			11
12	have reported the historical costs of the assets			12
13	consistent with the prior years, and have ensured			13
14	that depreciation expense is reported on straight			14
15	line. This adjustment is necessary to reverse the			15
16	re-valuation of historical cost.			16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,087)		49

Summary A

12/31/01

[illegible]

Facility Name & ID Number **MONTEBELLO HEALTHCARE CENTER**# **0031468**

Report Period Beginning:

1/1/01

Ending:

12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Mariner Post Acute Network	100.00%	\$ 343	\$ 343 1
2	V	6 Repairs and Maintenance		Mariner Post Acute Network	100.00%	161	161 2
3	V	19 Professional Services		Mariner Post Acute Network	100.00%	3,393	3,393 3
4	V	20 Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	106	106 4
5	V	10 Nursing and Medical Records		Mariner Post Acute Network	100.00%	10,339	10,339 5
6	V	21 Clerical and General Office Exp		Mariner Post Acute Network	100.00%	99,642	99,642 6
7	V	24 Travel and Seminar		Mariner Post Acute Network	100.00%	10,559	10,559 7
8	V	26 Insurance Premium		Mariner Post Acute Network	100.00%	(2,138)	(2,138) 8
9	V	36 Depreciation		Mariner Post Acute Network	100.00%	12,170	12,170 9
10	V	36 Taxes-Property		Mariner Post Acute Network	100.00%	511	511 10
11	V	36 Rental & Leasing		Mariner Post Acute Network	100.00%	3,074	3,074 11
12	V	36 Lease Expense		Mariner Post Acute Network	100.00%	1,626	1,626 12
13	V	36 Property Insurance		Mariner Post Acute Network	100.00%	1	1 13
14	Total		\$			\$ 139,787	\$ * 139,787 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER # 0031468 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **MONTEBELLO HEALTHCARE CENTER**# **0031468**

Report Period Beginning:

1/1/01Ending: **12/31/01**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Mariner Post Acute NetworkStreet Address One Ravine Dr., Suite 1500City / State / Zip Code Atlanta, GA 30346Phone Number (770) 379-8203Fax Number (770) 399-1971

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs		\$ 20,767	\$		\$ 343	1
2	6	Repairs and Maintenance	Facility Costs		9,731			161	2
3	19	Professional Services	Facility Costs		205,127			3,393	3
4	20	Fees, Subscriptions, Promotions	Facility Costs		6,427			106	4
5	10	Nursing and Medical Records	Facility Costs		67,554			10,339	5
6	21	Clerical and General Office Exp	Facility Costs		6,582,242			99,642	6
7	24	Travel and Seminar	Facility Costs		638,416			10,559	7
8	26	Insurance Premium	Facility Costs		(129,286)			(2,138)	8
9	36	Depreciation	Facility Costs		735,846			12,170	9
10	36	Taxes-Property	Facility Costs		30,882			511	10
11	36	Rental & Leasing	Facility Costs		185,889			3,074	11
12	36	Lease Expense	Facility Costs		98,311			1,626	12
13	36	Property Insurance	Facility Costs		76			1	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 8,451,982	\$		\$ 139,787	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																
1. Real Estate Tax accrual used on 2000 report.	\$ 59,027		1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$ 45,885		2																													
3. Under or (over) accrual (line 2 minus line 1).	\$ (13,142)		3																													
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$ 67,039		4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$ 53,897		7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td>1996</td><td style="text-align: right;">53,765</td><td style="text-align: center;">8</td></tr> <tr><td>1997</td><td style="text-align: right;">52,470</td><td style="text-align: center;">9</td></tr> <tr><td>1998</td><td style="text-align: right;">55,224</td><td style="text-align: center;">10</td></tr> <tr><td>1999</td><td style="text-align: right;">52,420</td><td style="text-align: center;">11</td></tr> <tr><td>2000</td><td style="text-align: right;">45,885</td><td style="text-align: center;">12</td></tr> </table>	1996	53,765	8	1997	52,470	9	1998	55,224	10	1999	52,420	11	2000	45,885	12	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td colspan="3" style="text-align: center;">FOR OHF USE ONLY</td></tr> <tr> <td style="width: 5%; text-align: center;">13</td> <td style="width: 70%;">FROM R. E. TAX STATEMENT FOR 2000</td> <td style="width: 25%; text-align: right;">\$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> </tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	14	PLUS APPEAL COST FROM LINE 5	\$	15	LESS REFUND FROM LINE 6	\$	16	AMOUNT TO USE FOR RATE CALCULATION	\$
1996	53,765	8																														
1997	52,470	9																														
1998	55,224	10																														
1999	52,420	11																														
2000	45,885	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2000	\$																														
14	PLUS APPEAL COST FROM LINE 5	\$																														
15	LESS REFUND FROM LINE 6	\$																														
16	AMOUNT TO USE FOR RATE CALCULATION	\$																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONTEBELLO HEALTHCARE CENTER COUNTY HANCOCK

FACILITY IDPH LICENSE NUMBER 0031468

CONTACT PERSON REGARDING THIS REPORT Cathy Simeoni

TELEPHONE (714)596-7713 FAX #: (714)596-7721

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>11-29-999-119</u>	<u>LOT B SUB (EX 2A SE COR & 377 2</u>	<u>\$ 45,884.94</u>	<u>\$ 45,884.94</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
		TOTALS	<u>\$ 45,884.94</u>	<u>\$ 45,884.94</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

25,581

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	305,550	1993	\$ 43,747	1
2					2
3	TOTALS	305,550		\$ 43,747	3

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER# 0031468

Report Period Beginning:

1/1/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	139		1993	1974	\$ 2,954,163	\$ 109,742	35	\$ 84,405	\$ (25,337)	\$ 675,664	4
5					46,664	1,167	20	2,333	1,166	18,677	5
6											6
7											7
8											8
	Improvement Type**										
9	INTERIOR BUILDING IMPROVEMENTS			1995	8,889		20	444	444	3,883	9
10	A/C UNITS			1996	2,775		20	139	139	892	10
11	WANDER GUARD SYSTEM			1996	887		20	44	44	283	11
12	SPRINKLER REPAIR			1997	2,239		20	112	112	653	12
13	SPRINKLER REPAIR			1997	2,317	116	20	116		563	13
14	CARPET IN LOBBY			1997	1,890	95	20	95		406	14
15	NURSES STATION			1997	2,363		20	118	118	668	15
16	A/C SYSTEMS			1997	8,325		20	416	416	2,268	16
17	NURSE STATION			1997	2,613		20	131	131	705	17
18	A/C			1997	2,969		20	148	148	689	18
19	LIGHT FIXTURES			1997	1,002		20	50	50	233	19
20	SPRINKLER REPAIR			1997	797		20	40	40	236	20
21	EXTERIOR SIGNS			1998	663	11	20	22	11	88	21
22	HEATING, VENTILATION & A/C			1998	2,643	37	20	77	40	308	22
23	HEATING, VENTILATION & A/C			1998	4,070	39	20	85	46	340	23
24	HEATING, VENTILATION & A/C			1998	6,800	51	20	113	62	452	24
25	PHONE SYSTEM			1998	1,338		20	61	61	244	25
26	NURSE STATION			1997	1,925		20	96	96	459	26
27	ADJUSTMENT 1998					(35)			35		27
28	WATER HEATER			1999	3,092	309	10	309	(0)	721	28
29	WATER PIPE HOOK-UP			1999	256	26	10	26	0	58	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Generator 100 amp Xfer Switch	2001	\$ 5,137	\$ 257	20	\$ 257	\$	\$ 257	37
38	3:Door Relays Instl	2001	912	76	10	76		76	38
39	2:w/g Monitor Digital Reset	2001	1,892	158	10	158		158	39
40	Use Tax:2W/G Monitor Digital	2001	8,191	683	10	683		683	40
41	Kohler Sink W/Guard Rims	2001	592	25	20	25		25	41
42	Use Tax:Kobler Sink W/ Guard Rim	2001	34	1	20	1		1	42
43	Royal 3.5Gal Water Saver	2001	325	14	20	14		14	43
44	Use Tax:Royal 3.5 Gal Water Saver	2001	20	1	20	1		1	44
45	Wanderguard & lock System Instl	2001	8,360	697	10	697		697	45
46	Air Handler & Coil Instl, Kitch	2001	915	31	20	31		31	46
47	2:Push-Button & Digital Resets	2001	822	55	10	55		55	47
48	Instl Ston A/C Unit, Kitchen	2001	1,475	74	10	74		74	48
49	Instl Charge, W/G System	2001	325	11	10	11		11	49
50	R Elec Water Heater Instl	2001	3,272	109	10	109		109	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,090,953	\$ 113,747		\$ 91,569	\$ (22,178)	\$ 710,679	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 634,834	\$ 72,588	\$ 66,861	\$ (5,727)		\$ 468,850	71
72	Current Year Purchases	16,196	1,617	1,617			1,617	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 651,030	\$ 74,205	\$ 68,478	\$ (5,727)		\$ 470,467	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,785,730	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 160,047	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (27,905)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,181,146	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Overhead allocation	\$ 636	\$ 32	\$ 178	86
87	Overhead allocation	1,136	57	289	87
88	Overhead allocation	2,127	106	468	88
89	Overhead allocation	360	18	76	89
90					90
91	TOTALS	\$ 4,259	\$ 213	\$ 1,011	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,770 Description: Vehicle \$10,785 Non-Medical Equipment \$1,985 See Page 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1999 Ford	\$ 983.58	\$ 10,785	17
18					18
19					19
20					20
21	TOTAL		\$ 983.58	\$ 10,785	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		10	hrs	\$ 1,088		\$ 2,850	\$	10	\$ 3,938	1
2	Licensed Speech and Language Development Therapist		598	hrs	13,080				598	13,080	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		1833	hrs	44,360		5,565		1,833	49,925	4
5	Physician Care			visits							5
6	Dental Care			visits			200			200	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts		276	11,885	44,470	276	56,355	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs			150			150	10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): AUDIOLOGIST						22			22	13
14	TOTAL				\$ 58,528	276	\$ 20,672	\$ 44,470	2,717	\$ 123,670	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,076	\$	1
2	Cash-Patient Deposits	102,137		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	494,395		3
4	Supply Inventory (priced at)	17,431		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 615,039	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	256,002		13
14	Buildings, at Historical Cost	2,030,109		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	315,443		16
17	Accumulated Depreciation (book methods)	(582,586)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,244,494		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(410,176)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,853,286	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,468,325	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 270,844	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,836		30
31	Accrued Taxes Payable (excluding real estate taxes)	690		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,039		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE 17.1	93,960		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 567,369	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED SCHEDULE 17.1	766,359		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 766,359	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,333,728	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,134,597	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,468,325	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,581,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,581,783	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	630,566	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 630,566	17
	B. Transfers (Itemize):		
18	Intercompany Transfers	(77,752)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (77,752)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,134,597	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,814,705	1
2	Discounts and Allowances for all Levels	(999,678)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,815,027	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	493,131	6
7	Oxygen	21,015	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 514,146	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	120	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	114,244	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,459	19
20	Radiology and X-Ray	71	20
21	Other Medical Services	39,153	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 230,047	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	1,195	28
28a	Miscellaneous Receipts	(1,324)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (129)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,559,091	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	572,331	31
32	Health Care	1,275,067	32
33	General Administration	636,706	33
B. Capital Expense			
34	Ownership	306,646	34
C. Ancillary Expense			
35	Special Cost Centers	61,672	35
36	Provider Participation Fee	76,103	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,928,525	40
41	Income before Income Taxes (line 30 minus line 40)**	630,566	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 630,566	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **MONTEBELLO HEALTHCARE CENTER**# **0031468**Report Period Beginning: **1/1/01**Ending: **12/31/01**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,937	2,075	\$ 46,314	\$ 22.32	1
2	Assistant Director of Nursing	1,538	1,648	30,373	18.43	2
3	Registered Nurses	7,719	8,270	132,849	16.06	3
4	Licensed Practical Nurses	13,498	14,461	193,947	13.41	4
5	Nurse Aides & Orderlies	59,991	64,273	539,130	8.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,346	3,584	84,549	23.59	7
8	Rehab/Therapy Aides	1,135	1,216	23,787	19.56	8
9	Activity Director	1,991	2,133	21,191	9.93	9
10	Activity Assistants	3,741	4,008	24,021	5.99	10
11	Social Service Workers	3,463	3,710	39,799	10.73	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,048	21,631	10.56	13
14	Head Cook	4,509	4,831	40,064	8.29	14
15	Cook Helpers/Assistants	8,742	9,366	62,134	6.63	15
16	Dishwashers					16
17	Maintenance Workers	2,431	2,605	27,324	10.49	17
18	Housekeepers	10,057	10,775	79,674	7.39	18
19	Laundry	5,816	6,231	36,390	5.84	19
20	Administrator	2,010	2,154	58,960	27.37	20
21	Assistant Administrator					21
22	Other Administrative	1,972	2,112	23,881	11.31	22
23	Office Manager					23
24	Clerical	4,317	4,625	45,181	9.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	503	538	5,770	10.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Driver & Marketin</u>	1,298	1,391	16,494	11.86	33
34	TOTAL (lines 1 - 33)	141,926	152,054	\$ 1,553,463 *	\$ 10.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	222	\$ 9,194	1-3	35
36	Medical Director	24	6,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	228	10,339	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,840	11-3	44
45	Social Service Consultant	36	2,205	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	546	\$ 30,178		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	114	\$ 3,827	10-3	50
51	Licensed Practical Nurses	214	6,260	10-3	51
52	Nurse Aides	229	4,610	10-3	52
53	TOTAL (lines 50 - 52)	557	\$ 14,697		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Rebecca Bliss	Administrator	0	\$ 64,486	Workers' Compensation Insurance	\$	41,615	IDPH License Fee	\$ 200
				Unemployment Compensation Insurance		19,111	Advertising: Employee Recruitment	
				FICA Taxes		114,159	Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance		100,070	Other License Fees	663
				Employee Meals			Dues	2,677
				Illinois Municipal Retirement Fund (IMRF)*			Home Office Allocation	106
				Other Employee Benefits		8,637		
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()
(List each licensed administrator separately.)							Non-allowable advertising	()
			\$ 64,486				Yellow page advertising	()
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	283,592		\$ 3,646
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Legal Fees	Legal Fees		\$ 1,404			\$	Out-of-State Travel	\$ 567
							In-State Travel	10,033
							Home Office Allocation	10,559
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 21,159
(If total legal fees exceed \$2500 attach copy of invoices.)								
			\$ 1,404					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number MONTEBELLO HEALTHCARE CENTER

STATE OF ILLINOIS

0031468

Report Period Beginning:

1/1/01

Ending:

Page 23

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTHCARE ASSOCIATION
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 76,103
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.